AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	ETED	
		155572	B. WIN			03/01/2	011
	PROVIDER OR SUPPLIE	ND REHAB CENTER	•	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
l	This visit was for Complaint IN00 Complaint IN00 Federal/State de allegations are complaint IN00 Facility number: Federal/State de allegations are complaint IN00 Facility number: Federal/State de allegations are complete in Inc. Survey dates: Federal Inc. Survey team; Kathleen (Kitty) Census bed type SNF/NF: 48 SNF: 9 Residential: 12 NCC: 11 Total: 80 Census payor tyy Medicare: 9 Medicaid: 45 Other: 26 Total: 80 Sample: 5	r the Investigation of 086395. 086395- Substantiated, ficiencies related to the ited at F314 and F514. Pebruary 28 & March 1, 000471 r: 155572 00290390 Vargas, RN, TC :	F00	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	
	i nese deficienci	es also reflect State					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HWJ811 Facility ID: 000471 If continuation sheet Page 1 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	l i	e survey pleted /2011
AUTUMN		ND REHAB CENTER	10352 1	ADDRESS, CITY, STATE, ZIP CO N 600 E COUNTY LINE F ITE, IN46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	findings cited in 16.2.	accordance with 410 IAC				
	Quality review com Bev Faulkner, RN	pleted on March 2, 2011 by				

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ΓED	
		155572	B. WIN			03/01/201	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER		l	TTE, IN46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314	Based on observa	ation, record review and	F03	14	Allegation of Credible Complia	ance (03/31/2011
SS=D	interview, the fac	cility failed to provide the			This Plan of Correction is		
	pressure ulcer tre	eatment as ordered by the			prepared and executed becau it is required by the provision of		
	•	note healing, for 1 of 4			State and Federal law and not		
		ed with pressure ulcers in			because Autumn Hills Health	I .	
	a sample of 5. (R	•			Rehabilitation Center agrees v	with	
	a sumple of J. (IN	coldone ii Dj			the allegations and citations		
	Findings in deads				listed. Autumn Hills Health ar		
	Findings include				Rehabilitation maintains that t	he	
					alleged deficiencies do not individually or collectively		
		as observed in bed on			jeopardize the health and safe	etv	
	2/28/11 at 12:05	p.m. The resident had			of the residents, nor are they		
	oxygen in use wi	th oxygen tubing in place			such character so as to limit o		
	around his ears.	The resident had no			capability to render adequate		
	dressing in place	behind his left ear. The			care. This Plan of Correction		
	resident was obs	erved at 1:20 p.m., and at			shall also operate as the facili	ty's	
		28/11, there was no			written credible allegation of compliance, please accept Ma	arch	
	-	d behind the resident's			31, 2011 as the date of		
	left ear.	d beining the resident's			compliance.F314 1) What		
	icit cai.				corrective actions will be		
	0 2/1/11 -4 0.5/	5 41 114			accomplished for those		
		5 a.m., the resident was			residents found to have been	n	
		He did not have a			affected by the deficient		
		behind his left ear.			practice: Resident #E: Area	to	
	Interview with L	PN # 1, at that time,			left ear was assessed and		
	indicated there w	as no dressing in place			wound was closed. MD was notified and treatment was		
	behind the reside	ent's left ear. She			changed to palliative Duode	_{rm}	
	indicated he was	to have a Duoderm			dressing every 3 days, and r		
	dressing in place	. The area behind his left			dressing was applied. Order		
		I to have a area 0.5			were also obtained to check		
		.2 centimeters in size, and			placement of wound dressin	gs	
	the area was red				every shift and replace if soi	led	
					or dislodged. 2) How other		
		ident was receiving			residents having the potentia	al	
	*	and the Hospice Nurse			to be affected by the same		
	and the facility s	taff nurses provided the			deficient practice will be		

000471

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF			ULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING COMPLETED		
		155572	B. WING 03/01/2011			03/01/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD	
AUTUMN HILLS HEALTH AND REHAB CENTER			1	TTE, IN46310		
				DEIVIO		_
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	pressure ulcer tre	eatments for the resident.			identified and what corrective	re l
					actions will be taken: All	
	The record for R	esident #E was reviewed			residents with dressing orde	
		00 a.m. The resident had			were checked for placement	1
		cluded, but were not			dressings, and all were in pl	
	"	·			as ordered. 3) What Measure	1
		stive heart failure,			will be put into place or what systemic changes will be ma	1
		accident (stroke) with			to ensure that the deficient	iu c
		s, and chronic sacral			practice does not recur: All	
	decubitus ulcer.	The resident had pressure			residents with dressing orde	ers
	ulcers behind his	left ear, behind his right			will be checked every shift for	
	ear and on his co	ccyx.			placement of dressings and	
		,			will be documented on the	
	There was a phys	sician's order, dated			treatment record. The woun	d
		-			nurse will randomly check a	t
		cated, "Cleanse behind			least 2 residents per day 5x/	1
		Clenz, pat dry, apply			to monitor compliance. The	
	Aquacel and cov	er with Duoderm, change			results of these audits will b	·
	q (every) 3 days.	"			forwarded to QA for review a	and
					any concerns will be	
	There was an ent	ry in the Nurse's Notes,			addressed. Licensed staff	
		2:00 p.m., that indicated,			have been in-serviced	
		r) received to apply Saf			regarding wound care, dressing change protocol ar	nd
	`	pply Aquacel et cover			monitoring of dressing	¹⁴
	· · · · ·				placement every shift.	
	with Duoderm, c	nange q 3 days."			Certified Nursing Assistants	
					will be in-serviced regarding	
		Pressure Ulcer Report			notifying nurse if dressing is	,
	Report" was revi	ewed. There was an			not present or becomes soil	ed
	entry, dated 2/22	/11, that indicated the			or dislodged during care, ar	
	resident had a Sta	age II (partial thickness			that CNA's are not to remove	e
		esenting as a shallow			dressings. 4) How the	
	_	red pink ulcer bed with			corrective actions will be	
	_				monitored to ensure the	
		are ulcer behind his left			deficient practice will not red i.e., what quality assurance	cur,
		asured 0.3 centimeters in			program will be put into	
	length by 0.5 cen	timeters in width with a			place: The QA committee w	, _{ill}
					piaco. The WA committee W	····

000471

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/01/2011	
	PROVIDER OR SUPPLIER	ND REHAB CENTER	STR 103	352 N	ADDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN46310	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	depth of less than Review of the formursing Compredated 2/28/11, in completed by the documentation in Nurse had visited p.m. until 2:40 p had changed the the resident's coot that a dressing we resident's left ear Interview with the 3/1/11 at 11:30 a nurses should reproduce the dressings when the or dislodged. She have been a dressing we resident's left ear physician. b. The forms title Comprehensive and the physician of the Hospice North Resident, and the Hospice North Resident Resident, and the Hospice North Resident	rm titled "Skilled hensive Assessment," dicated the form was a Hospice Nurse. The endicated the Hospice of the resident from 12:50 cm. She indicated that she pressure ulcer dressing to be except. She did not indicate as applied to the communicate as applied to the communicate of the should be indicated there should be indicated there should sing in place behind the communicated as ordered by the completed of the comprehensive did 2/28/11 indicated, and to coccyx. Stage III indicated, assue loss) with minimal staging on decubitus upon	TAC		review the results of these audits monthly x3 and then quarterly x2. 5. Date of compliance 3/31/11		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155572	A. BUI B. WIN			03/01/2	011
	PROVIDER OR SUPPLIER	ND REHAB CENTER	•	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2/21/11, indicate coccyx. Previous Coccyx open to a III decubitus 2 cr cm wide 1.2 cm of circular decub cm." The "Skille Comprehensive 2/14/11, indicate coccyx. No dress time of dressing The form titled "Report" was revientry, dated 2/4/1 resident had a St tissue loss with e muscle) pressure area measured 2 2 centimeters in than 1 centimeter dated 2/23/11, the pressure ulcer was cm in length, 1 cm in length, 1 cm in length, 1 cm depth. There was a phy 2/4/11, that indicate wound, pack look with Polymem for the control of the comprehensive and	d "Dressing change to dressing not in place. Air. Dimensions of stage of (centimeters) long 1.5 deep. Surrounding edges of the stage of the Assessment," dated dressing was on coccyx at change." Pressure Ulcer Report ewed. There was an l1, that indicated the age IV (full thickness exposed bone, tendon or enclose on his coccyx. The centimeters in length by width with a depth of less or. There was an entry, at indicated the coccyx as a stage III and was 1.6 m in width and .75 cm in exician's order, dated cated, "Cleanse coccyx sely with Alginate, cover oam and cover with equal (every other day)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			ILDING	NSTRUCTION	(X3) DATE COMPL 03/01/2	ETED
	PROVIDER OR SUPPLIER	ND REHAB CENTER	 10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN46310	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	3/1/11 at 11:30 a should have beer the resident's coc ordered by the pl Hospice Nurse m	ne Nurse Consultant on .m., indicated there in a dressing in place on sex pressure ulcer as mysician, when the made her visit. Trelates to Complaint				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A PLUI DING COMPLETE			ETED	
		155572	A. BUILDING B. WING 03/01/2011			011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER		l	TTE, IN46310		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID		1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
F0514	Based on record	review and interview, the	F05	14	Allegation of Credible	İ	03/31/2011
SS=D	facility failed to	ensure the assessment of			Compliance		
00 5		nd was documented for 1			This Plan of Correction is		
		viewed with pressure			prepared and executed		
		e of 5. (Resident #B)			because it is required by the	e	
	uiceis iii a saiiipi	e of 3. (Resident #B)			provision of State and Fede	eral	
					law and not because Autun	nn	
	Findings include	:			Hills Health and Rehabilitat	ion	
					Center agrees with the		
	The record for R	esident #B was reviewed			allegations and citations		
	on 2/28/11 at 2:3	0 p.m. The resident had			listed. Autumn Hills Health		
	diagnoses that in	cluded, but were not			and Rehabilitation maintain		
	limited to, diabetes, hypertension and				that the alleged deficiencies	s	
	bilateral below k				do not individually or		
					collectively jeopardize the		
	Pavious of the re	cord indicated the			health and safety of the		
					residents, nor are they of s	uch	
		sferred to the hospital			character so as to limit our		
		n altered mental status.			capability to render adequa		
		readmitted to the facility			care. This Plan of Correction	on	
	on 2/10/11.				shall also operate as the		
					facility's written credible		
	Upon readmissio	on to the facility the nurse			allegation of compliance,		
	_	mission assessment. The			please accept March 31, 20	ן 1רע	
	form titled "Adm				as the date of compliance.		
		l dated 2/10/11 was			F514		
		omments section of the			1) What corrective actions will	be	
		indicated the resident had			accomplished for those resident		
					found to have been affected by		
	,	er) x 4 cm reddened area			deficient practice:		
		arm, a 7 cm x 6 cm bruise					
	_	and a 0.5 cm x 0.9 cm x			Admission Nursing Assessment		
	0.3 cm coccyx pr	ressure wound. There was			Resident #B was updated as a la	ate	
	no assessment of	the resident's right			entry by LPN #3 to include		
	stump area.				assessment of right stump.		
					2) How other residents having t	he	
					,		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THIE TENIN	or condition	155572		LDING		03/01/2011	
		100072	B. WIN			00/01/2011	
NAME OF F	PROVIDER OR SUPPLIER			I	ADDRESS, CITY, STATE, ZIP CODE		
ALITLIMA		ND REHAB CENTER			N 600 E COUNTY LINE RD ITE, IN46310		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
	1 3	orders on the transfer			potential to be affected by the same deficient practice will be		
		spital indicated, "right			identified and what corrective		
		hange daily with ABD (a			actions will be taken:		
	large dry dressing	g) and Kerlix. Elevate the					
	stump at all time	s."			All Admission Nursing		
					Assessments completed since 3/	1/11	
	Review of the ho	spital wound care note,			have been reviewed to ensure		
	dated 2/8/11 at 1	514 indicated, "Consult			accuracy and completion of skin assessment documentation.	n	
		are re: right stump. Upon			assessment uveumentauvii.		
		atient) has 6.0 cm x 5.0			3) What Measures will be put in	nto	
	, a	sue injury) noted. We			place or what systemic changes		
	· •	rs and off load bilat			will be made to ensure that the		
	1	s. We will apply dry			deficient practice does not recu	r:	
	l `	** * *					
		with Kerlix, change			The Wound Nurse or designee	will	
	daily."				audit all Admission Nursing Assessments to ensure accuracy	,	
					and completion of skin assessm	I	
		sent to the hospital on			documentation. The results of		
	· ·	ot returned. Interview			these audits will be forwarded t	0	
	with the Nurse co	onsultant on 3/1/11 at			QA for review and any concern	s	
	11:00 a.m., indic	ated the resident was			will be addressed.		
	discharged at 2:0	4 p.m. on 2/15/11.			I : 1 -4-66 :		
	Review of the re-	cord indicated there was			Licensed staff were inserviced regarding accuracy and		
	no assessment of	the resident's right			completion of skin assessment		
		eadmission on 2/10/11			documentation on the Admission	n	
	1 ^	arge to the hospital on			Nursing Assessment.		
	2/15/11.	and to the hospital on					
	2 , 10, 11.				4) How the corrective actions w	ill	
	Unon admission	to the hospital a skip			be monitored to ensure the		
	_	to the hospital, a skin			deficient practice will not recur i.e., what quality assurance	,	
		completed. Review of the			program will be put into place:		
		note, dated 2/15/11 at					
	· · · ·	indicated the resident's			The QA committee will review	I	
	1 - 1	a black (non-viable) area			results of these audits monthly	x3	
	measuring 12 cm	by 18 centimeters.			and then quarterly x2.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572				LDING	ONSTRUCTION	(X3) DATE COMPL 03/01/2	ETED
	PROVIDER OR SUPPLIER	ND REHAB CENTER	•	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN46310		
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	a.m., indicated sl completed the "A Assessment" that indicated that she resident's right st document the ass the area was blact color. She indicated to the indicated the indicated to the indicated that she indicated to the indi	PN #3 on 3/1/11 at 9:00 ne was the nurse who admission Nursing that was dated 2/10/11. She had assessed the number but did not be sesment. She indicated only that he area was not ted the area was 6 cm by the Nurse Consultant on him., indicated there was not the resident's right mission to the facility on cated as assessment of ave been completed. The elates to Complaint the series of the resident's right mission to the facility on cated as assessment of the resident the series of the resident that the series of th			5. Date of compliance 3/31/11		